McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

Patient Name: _____ **Date:** _____

DOB: _____ **Phone:** _____

Address: _____

Insurance: _____

Diagnosis, estimated length of duration current episode of depression, and reason for referral:

_____

_____

Current medical conditions:

_____

_____

All current medications (for psychiatric or other medical conditions) and doses:

_____

_____

_____

_____

Medication trials during current episode of depression: Please include dose, duration, dates and response for each medication.

_____

_____

_____

Psychotherapy trials:

_____

_____

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

A completed referral form is required before a patient may complete his/her first TMS visit. If you have any questions regarding TMS, please call 617.855.2360.

Please fax the completed form to 617.855.3810 or mail to McLean Hospital, Attn: TMS Department, 115 Mill Street, Belmont, MA 02478.